ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
ENHANCED BENCHMARK PACKAGE FOR INDIVIDUALS WITH DISABILITIES, INCLUDING ELDERS, OR SPECIAL HEALTH NEEDS

1937(a), 1937(b) _X_ / The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a. ___ / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

NONE

b. _X_ / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

Recipients of Supplemental Security Income
SSI-Related Individuals
Recipients of Mandatory State Supplements
Recipients of State Supplementary Payments
Women Receiving Treatment for Brest and Cervical Cancer
Certain Children with Disabilities
Children in Foster Care or Subsidized Adoption
Other Medicaid Participants with Special Health Needs
Recipients of Hospice Care
Recipients of Long-Term Care

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

See Section 2.D of Attachment

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3 of Attachment.

c. _X_ / Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

See Section 1.C of Attachment

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

B. Description of the Benefits

_X_ / The State will provide the following alternative benefit packages (check all that apply). *Enhanced Plan*

1937(b)

1. _X_ / Benchmark Benefits

a. ___/ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b. ___/ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c. ___/ **Coverage Offered Through a Health Maintenance Organization (HMO)** - The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. _X_/ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3 of Attachment.

2. ___/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:_____.

a. ___/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of

benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. ___/ The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. ___/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) ___/ **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

___/ Inpatient and outpatient hospital services
___/ Physicians' surgical and medical services
___/ Laboratory and x-ray services
___/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
___/ Other appropriate preventive services, as designated by the Secretary
___/ Clinic services (including health center services) and other ambulatory health care services
___/ Federally qualified health care services
___/ Rural health clinic services

___/ Prescription drugs
___/ Over-the-counter medications
___/ Prenatal care and pre-pregnancy family services and supplies
___/ Inpatient Mental Health Services not to exceed 30 days in a calendar year
___/ Outpatient mental health services furnished in a State-operated facility and including community-based services
___/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
___/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements
___/ Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
___/ Dental services
___/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
___/ Outpatient substance abuse treatment services
___/ Case management services
___/ Care coordination services
___/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
___/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services
___/ Premiums for private health care insurance coverage
___/ Medical transportation
___/ Enabling services (such as transportation, translation, and outreach services)
___/ Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations:

___/ Home and community-based health care services
___/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

(3) Wrap-around/Additional Services

a. _X_ / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

b. _X_ / the State has elected to also provide wrap-around or additional benefits.

The state of Idaho has elected to cover children up to and including the month of their 21st birthday under EPSDT.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1. _X_ / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2. _X_ / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with sections 1905(a) (25) and 1905(t) of the Social Security Act.

3. ___/The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

4. ___/ Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5. _ _/ Alternative benefits will be provided through a combination of the methods described in item 1-4. Please specify how this will be accomplished.

D. Additional Assurances

a. _X_/ The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. _X_/ The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

_X_/ The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

_X_/ The State will implement this State Plan amendment on ***(July 1, 2006).***

TN No: 06-005
Supersedes TN No: 06-003

Approval Date: NOV 16 2006

Effective Date: OCT - 1 2006

ENHANCED PLAN
(For Individuals with Disabilities, Including Elders, or Special Health Needs)
BENCHMARK BENEFIT PACKAGE

Section 1: GENERAL OVERVIEW

1.A ADMINISTRATIVE AUTHORITY

As a condition for receipt of Federal funds under Titles XIX and XXI of the Social Security Act, the Idaho Department of Health and Welfare submits the following Enhanced Benchmark Benefit Package, and hereby agrees to administer the program in accordance with the provisions of Titles XI, XIX and XXI of the Act, and all applicable Federal regulations and other official issuances of the US Department of Health and Human Services.

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Enhanced Benchmark Benefit Package provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under section 1937 of the Social Security Act. (All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act).

All other provisions of the Enhanced Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Enhanced Benchmark Benefit Package described in this State Plan Amendment shall constitute the State Plan for Individuals with Disabilities or Special Health Needs as set forth in section 56-255, Idaho Code.

1.B POLICY GOALS

The broad policy goal for the provision of the Enhanced Benchmark Benefit Package for Individuals with Disabilities or Special Health Needs is to finance and deliver cost-effective individualized care.

Additional specific goals are:

- To emphasize preventive care and wellness;
- To empower individuals with disabilities to manage their own lives;
- To provide opportunities for employment for

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persons with disabilities; and
- To provide and to promote family-centered, community-based, coordinated care for children with special health care needs.

1.C GEOGRAPHIC CLASSIFICATION

Unless otherwise indicated, in the chart below, the benefits in the Enhanced Benchmark Benefit Package shall be in effect for all geographic and political subdivisions of the State.

Benefit	Geographic Area

1.D SERVICE DELIVERY SYSTEM

Each individual provided the Enhanced Benchmark Benefit Package under the State plan is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" as specified pursuant to a waiver program authorized under section of section 1937 of Social Security Act.

Certain covered individuals with selected chronic diseases may enroll with a Primary Care Case Management (PCCM) provider who receives an enhanced PCCM fee for measured clinical best practices related to chronic disease management. Enhanced PCCM fees are performance-based incentive payments made for individuals with chronic disease as defined in Attachment 3.1-F, Item B.3.

Unless otherwise indicated in the chart below, benefits may be obtained from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization, which provides such services or arranges for their availability on a pre-payment basis.

Primary Care Case Management System
Inpatient Hospital Services

Outpatient Hospital Services (excluding Emergency Services) Ambulatory Surgical Center Services Physician Services Other Practitioner Services (excl. Chiropractors and Podiatrists) Laboratory and Radiological (X-Ray) Services Inpatient Psychiatric Services Outpatient Mental Health Services Home Health Care Physical Therapy Respiratory Care Services Prosthetic Devices Medical and Surgical Services furnished by a dentist Rural Health Clinic Services Federally Qualified Health Center Services Independent School District Services EPSDT Pregnancy-Related Services
Managed Care Entity/Selective Contracting
Enhanced PCCM for Chronic Conditions Durable Medical Equipment and Supplies Eyeglasses Transportation Brokerage Targeted Case Management Services

Section 2. COVERED POPULATIONS

2.A COVERED INDIVIDUALS

The Enhanced Benchmark Benefit Package is available to the groups specified in this Section.

The conditions of eligibility that must be met are specified in the State plan.

The following groups will be offered opt-in alternative coverage under the Enhanced Benchmark Benefit Package covered under the State plan.

2.A.1 Recipients of Supplemental Security Income

The Enhanced Benchmark Benefit Package is available for aged, blind and disabled individuals receiving cash assistance as Supplemental Security Income (SSI). This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security

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Administration; and beginning January 1, 1981, persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

2.A.2 SSI-Related Individuals

The Enhanced Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month preceding the first month of eligibility under the requirements of section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619 (a) of the Act and were eligible for Medicaid; or

The Enhanced Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must:

- Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
- Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits;
- Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;
- Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

The Enhanced Benchmark Benefit Package is available for blind or disabled individuals who are at least 18 years of age and lose SSI eligibility because they become entitled to OASDI child benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

ENHANCED PLAN
(For Individuals with Disabilities, Including Elders, or Special Health Needs)
BENCHMARK BENEFIT PACKAGE

The Enhanced Benchmark Benefit Package is available for individuals who are ineligible for SSI or Optional State Supplements, because of requirements that do not apply under Title XIX of the Act.

The Enhanced Benchmark Benefit Package is available for aged, blind and disabled individuals who would be eligible for SSI, or an Optional State Supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

The Enhanced Benchmark Benefit Package is available for individuals who would be eligible for AFDC, SSI or an Optional State Supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

The Enhanced Benchmark Benefit Package is available for institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, these individuals must:

- Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
- Remain institutionalized; and
- Continue to need institutional care.

The Enhanced Benchmark Benefit Package is available for blind and disabled individuals who:

- Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;
- Were eligible for Medicaid in December 1973 as blind or disabled; and
- For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

The Enhanced Benchmark Benefit Package is available for individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash

assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). This also includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

The Enhanced Benchmark Benefit Package is available for individuals who are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977, and would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

The Enhanced Benchmark Benefit Package is available for disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21. and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

The Enhanced Benchmark Benefit Package is available for disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The Enhanced Benchmark Benefit Package is available for each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

2.A.3 Recipients of Mandatory State Supplements

The Enhanced Benchmark Benefit Package is available for Individuals receiving mandatory state supplements.

2.A.4 Recipients of State Supplementary Payments

The Enhanced Benchmark Benefit Package is available for Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act. The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement must be based on need and paid in cash on a regular basis and equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. Additionally, the supplement must be available to all individuals in each classification and available on a statewide basis and paid to one or more of the classifications of individuals listed below:

- All aged individuals.
- All blind individuals.
- All disabled individuals.
- Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CPR 435.230.

2.A.5 Women Receiving Treatment for Breast or Cervical Cancer

The Enhanced Benchmark Benefit Package is available for women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix. These women are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act, and are not eligible for Medicaid under any mandatory categorically needy eligibility group. Additionally, these women must not have attained age 65.

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The Enhanced Benchmark Benefit Package is available for women who are determined by a "qualified entity" as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients.

2.A.6 Certain Children with Disabilities

The Enhanced Benchmark Benefit Package is available for certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination of the cost effectiveness of caring for this group of disabled children at home as required under section 1902(e)(3)(B) of the Act.

In determining the cost effectiveness of caring for certain disabled children at home, a community care plan is developed for each applicant that identifies the medical services necessary to maintain the child in the community. This information is provided to the Department or its authorized agent. Costs for medical services that will be incurred by the Medicaid program are developed by the Department or its authorized agent and compared against the average cost of the appropriate level of institutional care determined by the Department or its authorized agent to be needed by the applicant. If the care plan costs exceed that of the appropriate level of institutionalization, then the Enhanced Benchmark Benefit Package is not allowable.

2.A.7 Children in Foster Care or Subsidized Adoption

The Enhanced Benchmark Benefit Package is available for all individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, as indicated below.

The Enhanced Benchmark Benefit Package is available for individuals for whom public agencies are assuming full or partial financial responsibility and who are:

- In foster homes (and are under the age of 21).
- In private institutions (and are under the age of 21).
- Individuals in NFs (who are under the age of 21).
- Individuals in ICFs/MR (who are under the age of 21).
- Individuals under age 21 receiving inpatient psychiatric

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services in a psychiatric hospital which is under the authority of the Division of Family and Community Services and certified by the Centers for Medicare and Medicaid.

- Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under Title IV-E of the Act.

The Enhanced Benchmark Benefit Package is available for a child for whom there is in effect a State adoption assistance agreement (other than under Title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement–

- Was eligible for Medicaid under the State's approved Medicaid plan; or

- Would have been eligible for Medicaid if the standards and methodologies of the Title IV-foster care program were applied rather than the AFDC standards and methodologies.

The State covers these individuals under the age of 21.

2.A.8 Other Medicaid Participants with Special Health Needs

The Enhanced Benchmark Benefit Package is available for individuals who would be eligible for Medical Assistance under the State plan who have a special health need, as identified through a health risk assessment completed in accordance with applicable Department rules, which would be more appropriately addressed through the provision of benefits under the Enhanced Benchmark Benefit Package.

2.A.9 Recipients of Hospice Care

The Enhanced Benchmark Benefit Package is available for individuals who would be eligible for Medicaid under this State plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

2.A.10 Recipients of Long-Term Care

The Enhanced Benchmark Benefit Package is available for

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institutionalized individuals and recipients of home and community-based services.

The Enhanced Benchmark Benefit Package is available for aged, blind and disabled individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period.

The Enhanced Benchmark Benefit Package is available for groups of individuals who would be eligible for Medicaid under this State plan if they were in a Nursing Facility (NF) or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group(s) covered are listed in the existing 1915(c) waivers. In the event an existing 1915(c) waiver is amended to cover any additional group(s), the Enhanced Benchmark Benefit Package is available to such group(s) on the effective date of the amendment. Eligibility begins on the first day of the 30-day period.

In determining level of care for recipients of long-term care Services, the Department provides for an evaluation (and periodic reevaluations) of the need for institutional level of care. Requirements for Level of Care Determinations are specified pursuant to existing waiver programs authorized under section 1915(c) of the Social Security Act.

2.B GENERAL CONDITIONS OF ELIGIBLITY

Each individual provided the Enhanced Benchmark Benefit Package must meet the financial conditions of eligibility described in the State plan.

Each individual provided the Enhanced Benchmark Benefit Package under the State plan must meet the applicable non-financial eligibility conditions.

2.D APPLICATION PROCEDURES

The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance.

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The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment in the Enhanced Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt out of the Enhanced Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

Section 3 COVERED BENEFITS

3.A GENERAL PROVISIONS

Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided in the Enhanced Benchmark Benefit Package as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

The Enhanced Benchmark Benefit Package includes the following categories of services:

- Inpatient and outpatient hospital services;
- Physicians surgical and medical services;
- Laboratory and x-ray services;
- Well-baby and well-child care, including age-appropriate immunizations; and
- Other appropriate prevention services as designated by the Secretary.

3.B. HOSPITAL SERVICES

3.B.1 Inpatient Services

The Enhanced Benchmark Benefit Package includes **Inpatient Hospital Services** permitted under sections 1905(a)(1) and

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2110(a)(1) of the Social Security Act. These services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be Medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

Organ Transplant Procedures. The Enhanced Benchmark Benefit Package includes organ transplant procedures which are provided under this State Plan.

Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described below.

Pursuant to the provisions of applicable Department rules, the Enhanced Benchmark Benefit Package may include organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers.

The treatment of complications, consequences or repair of any

medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department or its authorized agent is excluded from Medicaid payment.

Only Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive single or double lung, or combined heart-lung transplants from Medicare certified transplant centers. All other requirements regarding the pre-authorization of hospital stays and use of Medicare certified transplant facilities will continue to apply.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from Medicaid payment.

Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

3.B.2 Outpatient Services

The Enhanced Benchmark Benefit Package includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) and

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2110(a)(2) of the Social Security Act. These services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Service limitations for occupational therapy, physical therapy, and speech-language pathology services are listed in Section 3.M, Therapy Services.

Psychotherapy services are limited to forty-five (45) hours per calendar year. Services are provided by:

1. A psychiatrist or another physician licensed by the Board of Medicine or;
2. Other licensed professionals in accordance with 42 CFR 440.60(a) including:
   a. Psychologist licensed by the Board of Psychologist Examiners.
   b. Clinical Social Worker licensed by Board of Social Work Examiners.
   c. Clinical Professional Counselor licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board
   d. Marriage and Family Therapist licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board
   e. Certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner licensed by the Board of Nursing and, at a minimum, have a master's degree.
   f. Licensed Professional Counselor whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board.
   g. Licensed Masters Social Worker whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the board of Social Work Examiners.
   h. A Psychologist Extender, registered with the Professional Counselors and Marriage and Family Therapists Licensing Board and who is supervised by a Licensed Psychologist.

Psychological evaluation, speech and hearing evaluations, physical therapy evaluation and, occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible participant per calendar year.

Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.B.3 Emergency Hospital Services

The Enhanced Benchmark Benefit Package includes **Emergency Hospital Services** that are provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in the State plan.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be

excluded from the above limitation.

The limit of six (6) emergency room visits will be waived for EPSDT recipients.

3.C AMBULATORY SURGICAL CENTER SERVICES

The Enhanced Benchmark Benefit Package includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9), and 2110(a)(4) of the Social Security Act, including services provided under section 1905(a)(9).

Ambulatory surgical center services are outlined in applicable Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

3.D PHYSICIAN SERVICES

3.D.1 Medical Services

The Enhanced Benchmark Benefit Package includes **Physician Services** permitted under sections 1905(a)(5) and 2110(a)(4) of the Social Security Act. These services include office, clinic, outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

The Enhanced Benchmark Benefit Package includes treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Limitations. Limits on psychiatric evaluations and psychotherapy in any twelve (12) month period for Outpatient Mental Health Services shall not apply when such services are provided as Physician Services.

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3.D.2 Surgical Services

Surgical Services. The Enhanced Benchmark Benefit Package includes professional services rendered by a physician, surgeon or doctor of dental surgery.

Abortion Services. A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health.

Excluded Services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

3.E OTHER PRACTITIONER SERVICES

The Enhanced Benchmark Benefit Package includes **Other Practitioner Services** specified in sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include *medical care and any other type of remedial care recognized* under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioner Services. Certified pediatric or family nurse practitioner services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a)(21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

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Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Chiropractor Services. Chiropractic services are limited for payment to a total of twenty-four (24) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

Podiatrist Services. Podiatrist services are limited to treatment of acute foot conditions.

Optometrist Services. Optometrist services are limited to providing eye examination and eyeglasses covered under this State plan unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

3.F PRIMARY CARE CASE MANAGEMENT

The Enhanced Benchmark Benefit Package includes **Primary Care Case Management Services** permitted under in sections 1905(a)(25) and 2110(a)(21) of the Social Security Act. These services are provided by a primary care case manager consistent with a program authorized under section 1937 of the Social Security Act. All individuals opting into the Enhanced Benefit Package are required to enroll with a PCCM.

3.G PREVENTION SERVICES

The Enhanced Benchmark Benefit Package includes **Prevention Services** permitted under sections 1905(a)(3), 1905(a)(5), 1905(a)(6), 1905(a)(9), 1905(a)(13), 1905(a)(28), 2110(a)(3), 2110(a)(5), 2100(a)(8), 2100(a)(24) and 2110(a)(28) of the Social Security Act.

Health Risk Assessments. The Enhanced Benchmark Benefit Package includes a Health Risk Assessment which consists of:

- An initial health questionnaire, and
- A well child screen, or
- An adult physical.

The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

3.G.1 Well Child Screens.

The Enhanced Benchmark Benefit Package includes periodic medical screens completed at intervals recommended by the AAP, Committee in Practice and Ambulatory Medicine. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services". EPSDT RN screeners will be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian Health Clinic, or federally qualified health clinic.

One screen at initial program entry, up to the recipient's twenty-first birthday. The initial screen at program entry should constitute a health risk assessment as specified in applicable Department rules.

One (1) screen at or by age:

- one (1) month,
- two (2) months,
- three (3) months,

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- four (4) months,
- six (6) months, and
- nine (9) months.

One (1) screen at or by age:

- twelve (12) months,
- fifteen (15) months,
- eighteen (18) months, and
- twenty-four (24) months.

One (1) screen at or by age:

- three (3) years,
- four (4) years, and
- five (5) years.

One (1) screen at or by age:

- six (6) years,
- eight (8) years,
- ten (10) years,
- twelve (12) years, and
- fourteen (14) years.

One screen at or by age:

- sixteen (16) years,
- eighteen (18) years, and
- twenty (20) years.

Periodic screens and Interperiodic screens should constitute a health risk assessment as specified in applicable Department rules. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule above, and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management". Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.

Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and conducted by qualified professionals. EPSDT RN screeners will routinely refer all

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clients to primary care providers. EPSDT clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPSDT RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services (e.g. physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation). Efforts shall be made to assume that routine screening will not be duplicated for children receiving routine medical care by a physician.

EPSDT Registered Nurse Screener. Screening services may be provided by a licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions:

- Has completed a Child Assessment training course (or equivalent as approved by the Department) that prepares the RN to identify the difference between screening, diagnosis, and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. Training must include at least five (5) days didactic instruction in child health assessment, accompanied by a component of supervised clinical practice; and

- Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or federally qualified health clinic in order to provide linkage to primary care services. The employers must have a signed Medical Provider Agreement and possess an active Provider Number; or

- Has established and maintains an agreement with a physician or nurse practitioner for consultation on an as-needed basis.

3.G.3 Adult Physicals

The Enhanced Benchmark Benefit Package includes an annual preventive health visit consisting of procedures recommended by the US Prevention Services Task Force Guide to Clinical Preventive Services. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

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3.G.4 Screening services

Mammography Services. The Enhanced Benchmark Benefit Package includes screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

Diagnostic Screening Clinics. Services in the Enhanced Benchmark Benefit Package provided in a diagnostic screening clinic are outlined in applicable Department rules.

Limitations. Service limitations are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.

3.G.5 Prevention and Health Assistance (PHA) Benefits

The Enhanced Benchmark Benefit Package includes certain enhanced Prevention and Health Assistance (PHA) benefits for targeted individuals provided in accordance with applicable Department rules.

Enhanced PHA Benefits are individualized benefits to address targeted health behaviors. Authorizations will be managed by the State Medicaid agency.

PHA benefits made available under the Enhanced Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- Are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational material related to the condition.

PHA benefits may be used to purchase goods and services related to tobacco cessation and weight reduction/management in accordance with applicable Department rules. These goods and services may include nicotine patches or gum, weight-loss programs, dietary supplements, and other health related benefits.

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3.G.6 Nutrition Services

The Enhanced Benchmark Benefit Package includes intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.

Limitations. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits.

3.G.7 Diabetes Education and Training Clinics

The Enhanced Benchmark Benefit Package includes Diabetes Education and Training Clinics which provide diabetic education and training services are outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions.

The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.

To receive diabetic counseling, the following conditions apply to each patient:

- the patient must have a written order by his or her

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primary care physician or physician extender referring the patient to the program; and

- the physician may not use the formally structured program or a Certified Diabetes Educator as a substitute for basic diabetic care and instruction that the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents.

The medical necessity for diabetic education and training are evidenced by the following:

- a recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetic education; or,
- uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to manifestations, or
- recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.
- Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years.

Limitations. Diabetes education related to obesity shall not be subject to the above limitations when provided as PHA benefits.

3.H LABORATORY AND RADIOLOGICAL SERVICES

The Enhanced Benchmark Benefit Package includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) and 2110(a)(8) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

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Excluded Services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under this State plan

Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

3.1 PRESCRIBED DRUGS

The Enhanced Benchmark Benefit Package includes **Prescribed Drugs** permitted under sections 1905(a)(12), 2110(6) and 2110(a)(7) of the Social Security Act. These services include drugs prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins.

Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records including evidence of such medical necessity. Those records shall be made available to the Department upon request. The criteria used to determine medical necessity is stated in applicable Department rules.

Medicare Excluded Drug Products. Effective January 1, 2006, the Department will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B. The Department provides coverage for the following Medicare excluded or otherwise restricted drugs or classes of drugs or their medical uses to all recipients of Medical Assistance under this State plan, including

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full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

Lipase inhibitors subject to Prior Authorization.

Prescription Cough & Cold symptomatic relief.

Therapeutic Vitamins which may include:

- Injectable Vitamin B12;
- Vitamin K and analogues;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Nonlegend Products which may include:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts;
- Permethrin; and
- OTC products as authorized by applicable Department rules.

Barbiturates.

Benezodiazepines.

Additional Covered Drug Products. Additional drug products will be covered as follows:

- Therapeutic Vitamins;
- Injectable Vitamin B12 (cyanocobalamin and analogues);
- Vitamin K and analogues;
- Pediatric vitamin-fluoride preparations;
- Legend prenatal vitamins for pregnant or lactating women;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

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Prescriptions for non-legend products will be covered as follows:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts; and
- Permethrin, and
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents, based on Director approval which is determined by appropriate criteria including safety, effectiveness, clinical outcomes, and the recommendation of the P&T committee.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan. Prior authorization will be required for certain drugs and classes of drugs. The Department utilizes the Idaho State University School of Pharmacy for literature, research, and the state Drug Utilization Review (DUR) Board, and Medicaid's Medical Director and staff pharmacists within the Division of Medicaid, as the Prior Authorization committee. Criteria used to place drugs on prior authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in Section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization:

- Amphetamines and related CNS stimulants;
- Growth hormones;
- Retinoids;
- Brand name drugs when acceptable generic form is available;
- Medications otherwise covered by the Department for which there is a less costly, therapeutically

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interchangeable medication covered by the Department;

- Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines;
- Medications prescribed outside of the FDA approved indications;
- Lipase inhibitors; and
- FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been determined by the Department to be medically necessary.

Non-covered drugs must be discovered as being medically necessary by the screening services for individuals under twenty-one (21) years of age qualifying under EPSDT; and must be ordered by the physician and must be authorized by the Department or its authorized agent prior to purchase of the drug.

Limitation of Quantities. The Enhanced Benchmark Benefit Package has a limitation that no more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. To provide enhanced control over this limitation, the Point of Sale (POS) system has added an early refill edit to identify medication refills provided before at least seventy five percent of the estimated days supply has been utilized. This edit can be overridden by the pharmacy if a change in dosage is ordered. The edit is designed to prevent waste and abuse by preventing unnecessary refills, and identify clients who may be accessing multiple physicians and pharmacies and stockpiling medications. The following medications are the only exceptions to the 34 day supply limitation.

Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased:

- Cardiac glycosides;
- Thyroid replacement hormones;
- Prenatal vitamins;

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- Nitroglycerin sublingual and dermal patch products;
- Fluoride and vitamin fluoride combination products; and
- Nonlegend oral iron salts.

Oral contraceptive products may be purchased in a quantity sufficient for one (1), two (2), or three (3) cycles.

Excluded Drug Products. The following categories and specific products are excluded:

- Legend drugs for which Federal Financial Participation is not available
- Nonprescription items (without the Federal Legend), except permethrin, oral iron salts, disposable insulin syringes and needles.
- Ovulation stimulants and fertility enhancing drugs.
- Medications used for cosmetic purposes.
- Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

3.J FAMILY PLANNING SERVICES

The Enhanced Benchmark Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Family planning services and supplies for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Enhanced Benchmark Benefit Package covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

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The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Enhanced Benchmark Benefit Package includes **Services for Certain Individuals in Institutions for Mental Diseases** permitted under sections 1905(a)(14) of the Social Security Act.

Inpatient hospital services for individuals Age 65 or Over in Institutions for Mental Diseases include services provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

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Skilled care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care of recipients who do not require hospital care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.

Intermediate care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care and treatment of recipients who do not require hospital or skilled nursing care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.

Inpatient psychiatric facility services for individuals under 22 years of age include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital.

3.K.2 Outpatient Mental Health Services

In addition to Mental Health Services covered under Outpatient Hospital Services, the Enhanced Benchmark Benefit Package includes **Clinic Services** and other **Rehabilitative Services** permitted under sections 1905(a)(9), 2110(a)(5), 1905(a)(13) and 2110(a)(11) of the Social Security Act.

Mental Health Clinics. Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician. Services provided in a mental health clinic are outlined in applicable Department rules.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

Psychotherapy Services. As set forth in applicable Department rules are limited to forty-five (45) hours per calendar year.

Evaluation and Diagnostic Services. A combination of any evaluative or diagnostic services and care plan development is limited to twelve (12) hours for each eligible recipient per calendar year.

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Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive evaluative and diagnostic services in excess of the twelve (12) hours per calendar year limit.

Partial Care Services. Partial care treatment will be limited to thirty-six (36) hours per week, per eligible recipient.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive partial care treatment in excess of the thirty-six (36) hours per week limit.

3.K.3 **Psychosocial Rehabilitative Services (PSR)**

The Enhanced Benchmark Benefit Package includes **Psychosocial Rehabilitation (PSR) services** provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community. These services are outlined in applicable Department rules.

Limitations. The following service limitations apply to The Enhanced Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department:

- A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours in a calendar year.
- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.
- Community crisis support services are limited to a maximum of five (5) consecutive days and must receive prior authorization from the Division of Family and Community Services.
- Individual and group psychosocial rehabilitation services are limited to twenty hours (20) per week and must receive prior authorization from the Division of Family and Community Services. Services in excess of twenty (20) hours require additional review and prior authorization by the Department.

Excluded services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Treatment services rendered to recipients residing in inpatient medical facilities including nursing facilities or hospitals are

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excluded.

Recreational therapy, which includes activities which are primarily social or recreational in nature, is excluded.

Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job coaching, are excluded.

Staff performance of household tasks and chores, is excluded.

Client staffing within the same PSR agency, is excluded.

Services for the treatment of other individuals, such as family members, are excluded.

Any other services not listed in applicable Department rules, are excluded.

3.K.4 Case Management Services

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Persons with Mental Illness.

Recipients with severe disabling mental illness, as defined in applicable Department rules. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services.

Following the assessment(s) and determination of need for CM, a written service plan shall be developed and implemented as a vehicle to address the case management needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support system, and the CM provider. The written service plan must be signed by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under State law, indicating the services are medically necessary.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement,

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quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. Ongoing case management services are limited to a total of five (5) hours per calendar month. An additional three (3) hours of crisis care management are available if the individual meets established criteria. The Department may authorize additional crisis hours after the initial three (3) hours.

Payment for case management services under the Enhanced Benchmark Benefit Package does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3.L HOME HEALTH CARE

The Enhanced Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), 2110(a)(14) and 2110(a)(15) of the Social Security Act.

3.L.1 Home Health Services

The Enhanced Benchmark Benefit Package includes **Home Health Services** permitted under sections 1905(a)(7), 2110(a)(14) and 2110(a)(15) of the Social Security Act.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

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Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l).

Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, home health speech-language pathologist, or licensed nurse.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive in excess of one-hundred (100) visits per calendar year limit when prior authorized for medical necessity.

3.L.2 Private Duty Nursing

The Enhanced Benchmark Benefit Package includes **Private Duty Nursing Services** permitted under sections 1905(a)(8) and 2110(a)(15) of the Social Security Act.

Private Duty Nursing (PDN) is provided by a nurse licensed to practice in Idaho to certain eligible children for whom the need for such service has been identified in an EPSDT screen. Private Duty Nursing services are nursing services provided by a licensed professional nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. The nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Professional Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services.

PDN Services must be ordered by a physician, and include:
A function which cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and Administrative Rules of the Idaho State Board of Nursing.
An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes:

- A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medication or other

interventions; or
- A licensed or professional nursing assessment to evaluate the child's responses to interventions or medications.

Services delivered must be in a written plan of care, and the plan of care must be developed by a multi-disciplinary team.

The plan of care must be revised and updated as the child's needs change or upon significant change of the condition, but at least annually, and must be submitted to the Department or its authorized agent for review and prior authorization of service.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

PDN services must be authorized by the Department or its authorized agent prior to delivery of service.

PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences:

- Licensed Nursing Facilities (NF);
- Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR
- Licensed Residential Care Facilities;
- Licensed hospitals; and
- Public or private school.

3.M THERAPY SERVICE

The Enhanced Benchmark Benefit Package includes **Therapy Services** permitted under sections 1905(a)(11), 1905(a)(13) and 2110(a)(22) of the Social Security Act. These services include physical therapy, occupational therapy, and speech-language pathology services provided by a home health agency, independent provider, hospital outpatient facility, developmental disability agency, or medical rehabilitation facility.

Therapy services by an independent provider may be furnished by the following providers:

- Physical therapist who in accordance with 42 CFR 440.110(a) is licensed by the PT Licensing Board within the Board of Occupational Licensing.
- Occupational Therapist who in accordance with 42 CFR 440.110(b) is licensed by the Board of Medicine.
- Speech-Language Pathologist who in accordance with 42 CFR 440.110(c), is licensed by the Speech and Hearing Services Licensure Board within the Board of Occupational Licensing.

All therapy services are provided according to a written physician order as a part of a plan of care, and are provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office.

Respiratory care services may be furnished to Individuals less than twenty-one (21) years of age qualifying under EPSDT.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

Physical therapy, occupational therapy, and speech-language pathology services are limited to:

- Twenty-five (25) physical therapy visits per calendar year; and
- Twenty-five (25) occupational therapy visits per calendar year; and
- Forty (40) speech-language pathologist visits per calendar year

Additional visits may be prior authorized when medically necessary. Included in this limitation are outpatient hospital facilities, independent therapy providers, and developmental disability agencies.

Home health agency visits by home health aides, nursing services, physical therapists, occupational therapists, and speech-language pathologists in any combination are limited to a total of one-hundred (100) visits per participant per calendar year. Included in the total visits are all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Audiology services are not provided for under home health services.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.N AUDIOLOGY SERVICES

The Enhanced Benchmark Benefit Package includes **Audiology Services** permitted under sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include services for individuals with hearing disorders provided by or under the supervision of an audiologist who is licensed by the Speech and Hearing Services Licensure Board in accordance with 42 CFR 440.110(c).

Audiology Services include audiometric services and supplies according to applicable Department rules. The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional audiology services services if determined to be medically necessary and prior authorized by the Department.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.

The Department will purchase one (1) hearing aid per recipient with prior approval of the Department. Follow up services are included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, in accordance with applicable Department rules, with the following exceptions:

- When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted; or
- Replacement hearing aids maybe authorized if the requirements in applicable Department rules Subsections 108.03.a. through 108.03.d are met.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

3.0 MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.0.1 Medical Equipment and Supplies

The Enhanced Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under sections 1905(a)(28), 2110(a)(12) and 2110(a)(13) of the Social Security Act. These services include durable medical equipment and other

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medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

The Department requires recipients to obtain certain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Items not specifically listed in applicable Department rules will require prior authorization by the Department or its authorized agent.

3.0.2 Specialized Medical Equipment and Supplies

The Enhanced Benchmark Benefit Package includes **Specialized Medical Equipment and Supplies** permitted under sections 1905(a)(4)(B) or 1915(c)(4)(B) of the Social Security Act.

Oxygen and related equipment is covered for Individuals under twenty-one (21) years of age qualifying under EPSDT, when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt of medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.

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Specialized Medical Equipment and Supplies are also covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.O.3 **Prosthetic Devices**

The Enhanced Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive more than one refitting, repair or additional prosthetic or orthotic devices in a calendar year.

3.P VISION SERVICES

The Enhanced Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. The Department will provide vision-screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain

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scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart). The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error.

Eyeglasses. Each recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or the Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less that the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized.

Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction.

The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under this State plan.

Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme medical condition preclude the use of conventional lenses.

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Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for individuals over the age of twenty-one (21), except when documented by the physician and/or optometrist that there has been a major change in visual acuity that cannot be accommodated in the existing frames. Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals over the age of twenty-one (21).

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services

The Enhanced Benchmark Benefit Package includes **Medical and Surgical Services** furnished by a dentist permitted under sections 1905(a)(5)(B), 1905(a)(6) and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the limitations of practice imposed by state law, and according to applicable Department rules.

Dentures are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent. All hospitalizations for dental care must be prior approved by the Department or its authorized agent.

Excluded Services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Non-medically necessary cosmetic services are excluded from payment. Drugs supplied to patients for self-administration other than those allowed by applicable Department rules are excluded from payment.

3.Q.2 Other Dental Care

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The Enhanced Benchmark Benefit Package includes **Other Dental Care** permitted under sections 1905(a)(5)(B), 1905(a)(6) and 2110(a)(17) of the Social Security Act. These services include professional dental services provided by a licensed dentist or denturist as described in applicable Department rules. Specific services covered for children are stated in applicable Department rules.

The Department will provide dental services for children through the month of their twenty-first (21st) birthday including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services.

3.R ESSENTIAL PROVIDERS

The Enhanced Benchmark Benefit Package includes **Clinic Services and Rehabilitative Services** furnished by certain essential providers permitted under sections 1905(a)(9), 1905(a)(13) and 2110(a)(5) of the Social Security Act.

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other

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qualified providers

3.R.4 Independent Schools District Services

Independent School Districts that have entered into a provider agreement with the Department may bill for the following Basic and Enhanced Plan Services when they are identified on the student's Individual Education Plan (IEP). All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Covered Services.

Collateral Contact - Consultation or treatment direction about the student to a significant other in the student's life. Collateral contact may not be reimbursed for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings.

Medical Equipment and Supplies - Medical equipment and supplies as allowed under 440.70 that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services - Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non-routine medications not identified on the IEP as a health related service are not reimbursable

Occupational Therapy and Evaluation - Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered.

Personal Care Services - School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school.

Physical Therapy and Evaluation

Psychological Evaluation

Psychotherapy

Psychosocial Rehabilitation and Evaluation - Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, and coping skills.

Intensive Behavioral Intervention - Short term, one on one comprehensive interventions that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.

Speech/Audiological Therapy and Evaluation

Social History and Evaluation

Transportation - Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretive Services - May only be billed when the student needs the services of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

Limitations.

School Districts are subject to the limitations for covered services. Services provided by schools do not count towards the limitations for other service providers. Services beyond the scope of service limitation must be identified in an EPSDT screen, found to be medically necessary, and prior authorized.

Excluded Services: Vocational, Educational and Recreational services are not reimbursable under the Benchmark Plans.

3.S MEDICAL TRANSPORTATION SERVICES

The Enhanced Benchmark Benefit Package includes **Medical**

Transportation Services permitted under sections 1905(a)(26), 1905(a)(6) and 2110(a)(17) of the Social Security Act.

These services include transportation services and assistance for eligible persons to medical facilities.

Necessary transportation includes transportation for full benefit dual eligible individuals to acquire their Medicare Part D prescription medications.

Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

The Department operates a Brokered Transportation system. The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon the request of CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

The Department will operate the broker system without regard to the statewideness requirements of section 1902(a)(1) of the Social Security Act. The broker system is operated only in Region 5, Region 6, and Region 7.

The Department will operate the broker system without regard to the freedom of choice requirements of section 1902(a)(23) of the Social Security Act. Recipients are required to use transportation providers with established agreements under the broker system.

Transportation services under the broker system will include:

- Wheelchair van;
- Taxi;
- Stretcher care;
- Bus passes;
- Tickets;
- Secured transportation; and
- Such other non-emergency transportation covered under the State Plan.

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the

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Enhanced Benchmark Benefit Package covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Enhanced Benchmark Benefit Package are excluded.

3.T LONG-TERM CARE SERVICES

3.T.1 Nursing Facility Services

The Enhanced Benchmark Benefit Package includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Limitations. The following service limitations apply to Medical Assistance covered under this State plan.

Skilled nursing facility services must have prior authorization before payment is made. For individuals age 21 and older, such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment.

Nursing facility care services must have prior authorization before payment is made. For individuals under 21 years of age, such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to the eligibility for skilled nursing care services and authorization of payment.

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3.T.2 Personal Care Services

The Enhanced Benchmark Benefit Package includes **Personal Care Services** permitted under sections 1905(a)(24) and 2110(a)(14) of the Social Security Act when prior authorized by the Department.

Personal care services may be furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

- provided in accordance with a plan of care;
- provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
- provided in the participant's home.

Providers who are expected to carry out training programs for developmentally disabled participants must be supervised at least every ninety (90) days by a Qualified Mental Retardation Professional (42 CFR 483.430(a))

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Services are limited to sixteen (16) hours per calendar week, per eligible participant.

Participants under twenty-one (21) years of age (qualifying under EPSDT), may receive personal care services in excess of sixteen hours of service per week.

3.T.3 Home and Community-Based Services

Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.T.4 Case Management Services

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

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Personal Care Service Recipients.

Recipients who have been approved for personal care services and who require and desire assistance to adequately access services necessary to maintain their own independence in the community.

The scope and amount of services will be determined by the Department based on the individual community service plan.

Services are delivered by eligible case management agencies to recipients who have been determined eligible for Personal Care Services. Case management is an individualized service provided by an employee of a qualified case management provider agency acting in the role of a coordinator of multiple services to insure that the various needs of the individual are assessed and met.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Payment for case management services under the Enhanced Benchmark Benefit Package does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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3.U HOSPICE CARE

The Enhanced Benchmark Benefit Package includes **Hospice Care** permitted under sections 1905(a)(18) and 1905(o) of the Act.

Hospice Care is provided only to terminally ill recipients when furnished by a Medicare certified hospice.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Hospice care provides for eight benefit periods which coincide with each recipient's monthly eligibility recertifications. A recipient is provided up to eight calendar months of hospice care. The benefit period starts on the first day of the month in which hospice was elected and hospice is automatically renewed until the date of the recipient's death, revocation, or failure to meet monthly eligibility requirements. The recipient will have at least 210 hospice days available.

Respite days are limited to five days per benefit period (calendar month).

3.V DEVELOPMENTAL DISABILITY SERVICES

3.V.1 Intermediate Care Facility Services

The Enhanced Benchmark Benefit Package includes **Intermediate Care Facility Services** permitted under section 1905(a)(15) of the Social Security Act. Services in an Intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) are for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Intermediate care services including such services in a public institution for the mentally retarded or persons with related conditions must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to eligibility for intermediate care services and authorization of payment.

Including such services in a public institution (or distinct part

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thereof) for the mentally retarded or persons with related conditions.

3.V.2 Developmental Disability Agency Services

The Enhanced Benchmark Benefit Package includes **Community-Based Services** permitted under sections 1905(a)(13) and 2110(a)(14) of the Social Security Act. These services include Rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules.

EPSDT Rehabilitation Intensive Behavioral Interventions (IBI). Intensive Behavioral Interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. IBI is available only to children birth through age twenty-one (21) who have self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure and play skills. IBI is available in a developmental disability agency, Idaho public school districts or other public educational agencies. IBI services cannot exceed thirty (30) hours per week in combination with developmental therapy and occupational therapy in a developmental disability agency. IBI services are limited to a three (3) year duration in developmental disability agencies, and Idaho public school districts or other public educational agencies. After three (3) years the expectation is that these clients will be reassessed and transitioned into appropriate services.

A professional qualified to provide or direct the provision of Intensive Behavioral Intervention must have Department approved training and certification which addresses course work, experience, ethical standards, continuing education and demonstrated competencies and:

- have at least a bachelor's degree in psychology, special education, social work, applied behavior analysis, speech and language pathology, occupational therapy, physical therapy, deaf education, elementary education or a related field; or
- be a Licensed Professional Counselor.

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Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Rehabilitative services provided by Developmental Disabilities Agencies are limited to twelve (12) hours reimbursable time allowed for the combination of all evaluations or diagnostic services; the limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy will be waived for EPSDT recipients.

3.V.3 Other Home and Community-Based Services

Other Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.V.4 Case Management Services

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Developmentally Disabled

Developmentally disabled recipients, including eligible individuals between the ages of eighteen (18) and twenty-one (21) who have transition plans developed by the school system which identify service coordination (i.e. case management) as necessary.

The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential and social services.

Service coordination should enable the recipient whenever possible. Enablement includes, but is not limited to, providing information, assuring that all placements in the service delivery system are within the least restrictive environment possible, ensuring that all placements are community based, ensure that all providers comply with client's rights as specified in the DD Act, assuring that no one will be denied service

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coordination on the basis of the severity of physical or mental handicap.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package includes covered under the State plan.

Payment for case management services under the Enhanced Benchmark Benefit Package does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3.Y SPECIAL SERVICES FOR CHILDREN/EPSDT

EPSDT Services. The Department meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Social Security Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services.

The Enhanced Benchmark Benefit Package includes early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Services under EPSDT are available to recipients up to and including the month of their twenty-first (21st) birthday.

EPSDT services include diagnosis and treatment involving medical care within the scope of Medical Assistance, as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services

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provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Enhanced Benchmark Benefit Package will not be subject to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Children Requiring Case Management Service under EPSDT.

Case Management Services for children under EPSDT require prior authorization and a Service Plan completed by the Department or its authorized agent for the initial Service Plan prior to delivery of case management services. The case manager must review and update the approved service plan for service coordination at least annually. The Department must approve the Service Plan for continued prior authorization.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

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The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

3.Z SPECIFIC PREGNANCY-RELATED SERVICES

The Enhanced Benchmark Benefit Package includes **Pregnancy-related services,** including family planning services, and postpartum services available for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls and are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

The State provides the full range of Medicaid services with limitations as elsewhere described in the Enhanced Benchmark Benefit Package to eligible pregnant women if such service is related to a medical condition identified by the Department or its authorized agent as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

For presumptively eligible pregnant women, ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under this State plan.

Ambulatory prenatal care for pregnant women is furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complications thereof are covered services to pregnant women. Limitations as described elsewhere in the Enhanced Benchmark Benefit Package are applicable.

Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

Special services related to pregnancy. When ordered by the patient's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the 60th day following delivery occurs.

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Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. A single payment for each month of service provided is made.

Individual and Family Medical Social Services. Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.

Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available.

Nursing Services. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided.

Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized.

Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.

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The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s)-as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Pregnant and Parenting Teens and their Infants.

Eligible pregnant teens seventeen (17) years of age or younger at the time of conception. Teens who qualify for case management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until 72 hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. Teens and infants must live in Adams, Washington, Payette, Gem, Canyon, or Owyhee counties.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

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3.AA SUBSTANCE ABUSE TREATMENT SERVICES

The Enchanced Benchmark Benefit Package includes Substance Abuse Treatment Services permitted under 1905(a)(9) of the Social Security Act and provided to individuals screened eligible for such services in accordance with applicable Department rules.

Covered Services:

- Assessment: maximum of eight (8) hours per year- includes annual assessment, interviewing and treatment plan building. Each individualized treatment plan is based on a biopsychosocial assessment of the participant's alcohol or substance abuse treatment needs. This assessment must be conducted utilizing a Department-approved standardized assessment tool.
- Drug screening: maximum of three (3) per week. Urinalysis to detect the presence of alcohol or drugs.
- Individual counseling: maximum of twelve (12) hours per week. Service provided to a participant in a one-on-one setting (one participant and one counselor). The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both.
- Group counseling: maximum of twelve (12) hours per week. Service provided to participants in a peer group setting. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both.
- Service coordination: maximum of four (4) hours per week and fifty five (55) hours per year. Service coordination consists of:
    - Finding, arranging and assisting the participant to gain access to and maintenance of services, supports and community resources
    - Monitoring participant progress- includes verifying that services are received and are satisfactory to the participant, ascertaining that services meet the participant's needs, documenting progress and any revisions in services needed, and making alternative arrangements if services become unavailable to the participant.
    - Planning- community reintegration planning and exit planning

  Service coordination is provided on an outpatient basis to participants who are at risk of being institutionalized.

Substance abuse treatment services are limited to a five (5)-year period beginning on the date of the initial assessment and regardless of the source of payment for the initial assessment. This lifetime cap only applies to participants twenty-two (22) years of age and older.

Provider qualifications:

Providers of outpatient substance abuse treatment services must maintain a statewide network of approved programs and treatment facilities in accordance with applicable Department rules.

Individuals must provide services through a program with a certificate of approval issued by the state.

Individuals providing services to participants must have a criminal history check.

Assessment: must be conducted by an individual who is:

- Certified in administering the standardized assessment tool being utilized

And, who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria:

- Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC).
- Licensed professional counselor or Licensed clinical professional counselor.
- Licensed physician.
- Licensed psychologist.
- Licensed physician assistant, nurse practitioner or clinical nurse specialist.
- Licensed clinical or licensed masters social worker.
- Licensed marriage and family therapist.
- Licensed associate marriage and family therapist.

Drug screening: urinalysis must be conducted in a laboratory that is under the direction of a physician or other licensed provider.

Therapy and counseling services and Service Coordination must be provided by an individual who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria:

- Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC)
- Licensed professional counselor or Licensed clinical professional counselor.
- Licensed physician.
- Licensed psychologist.
- Licensed physician assistant, nurse practitioner or clinical nurse specialist.
- Licensed clinical or licensed masters social worker.
- Licensed marriage and family therapist.
- Licensed associate marriage and family therapist.

The Department requires participants to obtain outpatient services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.